Wraparound Milwaukee – REACH Program
DISENROLLMENT DOCUMENTATION

Name of Child_____

Name of Parent or Guardian _____ M.A. Case Number _____
(to be filled in by Wrap staff)

Requested Date of Disenrollment_____

Date of Disenrollment Plan of Care Meeting _____   DOB _____

Signatures of Team Members Present at the Disenrollment Team Meeting:

<u>Team Member Signatures</u>

_____	_____	_____
Youth	Team Member	Role
_____	_____	_____
Parent/Guardian	Team Member	Role
_____	_____	_____
Care Coordinator	Team Member	Role
_____	_____	_____
Supervisor	Team Member	Role

Note: If unable to obtain parent/guardian and/or youth signatures at disenrollment plan of care, please indicate reason and attach progress notes from previous month and certified mail receipts.

Reason for Disenrollment:

☐ Youth/family have made substantial progress and needs have been met.
☐ Youth/family have made progress, some needs remain. Continuing services have been arranged.
☐ Youth's Medicaid eligibility changes.
    Level of Progress Made: ___ *Substantial* ___ *Some* ___ *Needs Not Met*
☐ Youth/family moved out of county.
    Level of Progress Made: ___ *Substantial* ___ *Some* ___ *Needs Not Met*
☐ Youth/family no longer desire Wraparound services.
    Level of Progress Made: ___ *Substantial* ___ *Some* ___ *Needs Not Met*
☐ Family/Youth missing more than 30 days
☐ Other (explain): _____
    Level of Progress Made: ___ *Substantial* ___ *Some* ___ *Needs Not Met*

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Disenrollment Reviewed and Approved by:

_____   _____
                                                                                                             Date

_____   _____
                                                                                                             Date

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(For EDS Use Only)

Disenrollment is: ☐ Approved   Effective Date of Disenrollment _____
                              ☐ Denied   Reason for Denial _____

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